Correspondence

Seizures Associated With Smoking 'Crack'—A Survey of Adolescent 'Crack' Smokers

To the Editor: The neurologic aspects of cocaine abuse, including a detailed section on cocaine-induced seizures, were discussed comprehensively in the October 1988 issue of the journal.[1] I have just analyzed a survey of 279 mostly middle-class white adolescents who took cocaine before being admitted to one of a chain of private, modified-outpatient drug-abuse treatment facilities. The 279 respondents were subdivided into four groups: 149 adolescents who "snorted" cocaine and never smoked "crack"; 87 who had smoked "crack" 1 to 9 times, designated as experimenters; 20 who had smoked "crack" 10 to 50 times, designated as the intermediate group; and 23 who had smoked "crack" more than 50 times, designated as the heavy-use group.

Approximately 30% of those who "snorted" but never smoked cocaine versus 50% of experimenters, 60% of the intermediate group, and 80% of the heavy-use group responded in the affirmative when queried about signs and symptoms of addictive cocaine use. These included preoccupation with thoughts of cocaine, inability to cut down on amount or frequency of cocaine use, inability to refuse an offer of cocaine, and inability to save leftover cocaine for future use. Brain seizures were noted by 0%, 1%, 10%, and 9% of each of the above groups, respectively ($P < .0001$). Loss of consciousness while smoking "crack" was noted by 2%, 10%, and 30% of the 130 adolescent "crack" smokers.

More than any other drug in widespread use in this country, "crack" cocaine will cause neurologic problems serious enough to bring the user to a physician. Unexplained seizures that occur after age 12 should prompt physicians to order a urine toxicology screen by an immunoassay method, which can detect cocaine in much smaller amounts than the traditional thin-layer chromatography broad spectrum drug screen used by most emergency medicine facilities.

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Treating Neurosyphilis

To the Editor: In his excellent review on neurosyphilis in the July 1988 issue, Dr Kenneth Jordan makes two conclusions that deserve some comments.[1]

Dr Jordan states that the sensitivity of today's cerebrospinal fluid (CSF) VDRL test is much higher than the sensitivity of the classic CSF Wassermann test. The higher sensitivity of the blood VDRL test compared with the blood Wassermann test is well known; however, the flocculation tests in the CSF have been considered less satisfactory than the Wassermann test.[2]

In my experience the CSF Wassermann test done as described by Kolmer and co-workers[3] is more reliable than the CSF VDRL. In an evaluation of 44 patients with active symptomatic neurosyphilis and with positive CSF Wassermann test results, I found 6 patients with false-negative CSF VDRL test results.

Another important conclusion by Dr Jordan is that "the treatment of active neurosyphilis should produce uninterrupted CSF penicillin concentrations of no lower than 0.031 IU per ml for 15 to 21 days." There are strong theoretical data supporting this conclusion, but my many years of clinical experience do not agree with it.

The efficacy of intramuscular penicillin in the treatment of neurosyphilis was witnessed soon after excellent results were reported in the treatment of early syphilis. The penicillin doses used in the treatment of neurosyphilis in those days were low, but treatment failures occurred in about 10% of these patients.[4] It is unlikely that the penicillin levels now proposed as therapeutic had even been attained by the doses used in those first series. So at least 90% of patients with neurosyphilis were successfully treated with penicillin doses now considered insufficient on a theoretical basis. It is possible that other factors are responsible for the treatment failures.

Therapeutic failures in neurosyphilis can occur even after high doses of penicillin are administered. A total of 41 patients with active neurosyphilis were treated in our service with at least 20 million IU of intravenous penicillin daily for 20 days.[5,6] Three patients still had more than 5 cells per μl one year after treatment, and in accordance to Dattner's criteria, they should be considered therapeutic failures.[7] I agree, therefore, with Dr Jordan that "whichever regimen is chosen, careful follow-up is necessary to ensure a cure."

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Neonatal-Perinatal Medicine—A Model Subspecialty

To the Editor: Subspecialization has been the unavoidable consequence of the success of modern medical science. It threatens, in principle, the subjectivity of the patient because of the assignment of expertise according to the categories of understanding related to organ systems, diseases, body parts, procedures, and so forth. The actual performance of services by experts is often limited to practices understood to be relevant to their designated categories of special knowledge. Ironically, in the interest of complete care, the patient is approached as one might approach a complex machine. In many important and convenient ways, the human body en-